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Mercredi 12 avril 2017

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Protecting Patients Act, 2017

Comité permanent de l'Assemblée législative

Loi de 2017 sur la protection
des patients

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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON
THE LEGISLATIVE ASSEMBLYCOMITÉ PERMANENT DE
L'ASSEMBLÉE LÉGISLATIVE

Wednesday 12 April 2017

Mercredi 12 avril 2017

The committee met at 1230 in committee room 1.

The Chair (Mr. Monte McNaughton): Good afternoon, everyone. It's 12:30, so we'd like to begin. Welcome to the Standing Committee on the Legislative Assembly. We're here for public hearings on Bill 87.

SUBCOMMITTEE REPORT

The Chair (Mr. Monte McNaughton): I'd like to move to Ms. Kiwala for the report of the subcommittee on committee business. Ms. Kiwala?

Ms. Sophie Kiwala: Thank you, everyone, for being here today.

Your subcommittee on committee business met on Wednesday, April 5, 2017, to consider a method of proceeding on Bill 87, An Act to implement health measures and measures relating to seniors by enacting, amending or repealing various statutes, and recommends the following:

(1) That the committee hold public hearings on Bill 87 in Toronto on Wednesday, April 12 and 26, 2017, and Wednesday, May 3 and 10, 2017.

(2) That the Chair write to the House leaders requesting that a motion be moved in the House authorizing the committee to meet from 12:30 p.m. until 1 p.m., in addition to its regularly scheduled meeting times, on Wednesday, April 12 and 26, 2017, and Wednesday, May 3 and 10, 2017.

(3) That the Clerk of the Committee, with the authorization of the Chair, post information regarding public hearings on the Ontario parliamentary channel, the Legislative Assembly website and with the CNW news-wire service.

(4) That the Clerk of the Committee, with the authorization of the Chair, place an advertisement in the *Turtle Island News* and a major newspaper for one day in each of the following regions: northeastern, northwestern, southwestern and eastern Ontario; and that the advertisement be placed in one French-language weekly.

(5) That interested parties who wish to be considered to make an oral presentation contact the Clerk of the Committee by 12 noon on Friday, May 5, 2017.

(6) That the Clerk of the Committee provide the members of the subcommittee with a list of requests to appear on the Monday morning at 9 a.m. of each week of public hearings, and that the members prioritize and return the list by 10 a.m. the same day.

(7) That groups and individuals be offered up to six minutes for their presentation, followed by up to three minutes of questions and comments from each caucus.

(8) That the deadline for written submissions be 5 p.m. on Monday, May 8, 2017.

(9) That the committee meet for clause-by-clause consideration of the bill on Wednesday, May 17 and 31, 2017.

(10) That the deadline for amendments be 12 noon on Monday, May 15, 2017.

(11) That the research officer provide an interim summary of the presentations by 5 p.m. on Monday, May 8, 2017.

(12) That the Clerk of the Committee, in consultation with the Chair, be authorized, prior to the passage of the report of the subcommittee, to commence making any preliminary arrangements necessary to facilitate the committee's proceedings.

The Chair (Mr. Monte McNaughton): Great. Thanks, Ms. Kiwala. Any debate? Shall the report carry? Carried.

I'd like to remind the committee that the final summary will be provided to committee members on Thursday, May 11, 2017, by 5 p.m.

PROTECTING PATIENTS ACT, 2017

LOI DE 2017 SUR LA PROTECTION
DES PATIENTS

Consideration of the following bill:

Bill 87, An Act to implement health measures and measures relating to seniors by enacting, amending or repealing various statutes / *Projet de loi 87, Loi visant à mettre en oeuvre des mesures concernant la santé et les personnes âgées par l'édiction, la modification ou l'abrogation de diverses lois.*

MS. SHEILA MACDONALD

The Chair (Mr. Monte McNaughton): We'll now move to presentations. We'll call upon Sheila Macdonald. Good afternoon. Each presenter will have six minutes for their presentation, followed by three minutes of questioning from each caucus, beginning with the official opposition. If you'd just state your name for Hansard, please, and begin your presentation.

Ms. Sheila Macdonald: My name is Sheila Macdonald. Thank you for the opportunity to speak today. I was a member of the Minister's Task Force on the Prevention of Sexual Abuse of Patients and the Regulated Health Professions Act, 1991. This task force was appointed by the Minister of Health in December 2014. I am a registered nurse and I have worked for the last 25 years with victims/survivors of sexual assault, so I have extensive experience and awareness of the impact of sexual violence on persons.

Every patient in Ontario—and that's all of us—has the right to safety in every interaction within the health care system. As health professionals, we want and we expect our patients to trust us in order to provide the best possible health care. Our patients assume they can trust their health professional, and when that trust is violated, the impact on the patient is significant.

That feels like an understatement. We heard from patients who have never again accessed health care services subsequent to being sexually abused by a health professional, now have life-changing health issues and still can't come forward to access help. The impact is profound. It's important that we acknowledge the power differential that exists between the patient and the professional, and the vulnerabilities that patients have when they come to seek assistance and how they can be exploited. By vulnerability, I mean anything from someone who's in pain, desperate for a diagnosis and treatment or in need of therapy of some sort. It puts people in vulnerable positions.

When the response by the existing structures to abuse is inadequate, public confidence in the system that is set up to protect them is eroded. Far too many Ontario patients do not have confidence in the current system. Tinkering will not regain public trust.

The need for significant change was apparent throughout this process. Far too often, the health regulatory colleges have not upheld the zero-tolerance standard, reflected in penalties such as gender restrictions, short-term suspensions and counselling for the professional. These penalties minimize the profound impact of the abuse on the patient, whose life is shattered by the actions of the perpetrator.

I am pleased to see the legislative changes as proposed in Bill 87. These changes are the beginning in improving the response to patients who have been sexually abused. However, these changes on their own are not enough to address the issues.

The 34 recommendations in our task force report are comprehensive and require an integrated, multi-sectoral approach to ensure an effective response to patients who come forward.

First, there needs to be financial investment in patients' rights and organizations that can do advocacy and provide services to support patients when they're seeking help. Patients need access to legal information and support at the outset of the report so that they are informed of their rights and options.

Second, there needs to be public education to increase awareness of the problem, its impacts and remedies.

Third, there needs to be widespread, mandatory education for all regulated health professionals as well as all students—our future professionals—so that there is a clear understanding of what constitutes sexual abuse of a patient, the power dynamics that exist, the impact on patients and the health professional reporting obligation when there is awareness of abuse being committed by another professional.

Fourth, there needs to be strengthened organizational commitment to addressing and responding to this issue within health care organizations through embedded patient safety accreditation and quality assurance standards.

Finally, the investigation and adjudication need to be through an independent body and not the college for the professional who the patient is bringing forward the complaint about.

Effective implementation of all the recommendations requires a commitment by government, education, law and health care systems to work collaboratively and progressively, with a focus on patient safety and dignity.

We need consistent and mandatory data collection and reporting on these cases to strengthen accountability and provide direction for further changes that are needed. The reporting must also be publicly available in order to have transparency. We should not have to rely on the media to know when we have failures in ensuring patient safety in Ontario.

Thank you again for today.

The Chair (Mr. Monte McNaughton): Thank you very much. We'll move to the official opposition and Mr. Bailey.

Mr. Robert Bailey: Thank you, Ms. Macdonald, for your presentation today, and your work on the committee as well.

You outlined a number of things that are in the proposal, in the bill, that you think will help. In the brief time we have, could you expand upon—if you could get two or three more things in the bill, what would they be? What do you think would lead to the most dramatic improvements over and above the ones that are in there now?

Ms. Sheila Macdonald: I think what's really critical is that patients have access to support when they come forward to make a report. There are not enough available services and awareness within communities province-wide, for someone to come forward who can help them even navigate in to the system. I think we could easily build on Legal Aid Ontario, in terms of access to legal information, so that patients know when they come forward what their options are, what their recourse is. They have no knowledge right now when they come forward. They're reliant on the college itself to provide that information.

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I think there needs to be independent oversight and adjudication of these cases. We need the independence, away from the colleges, where we can build the expertise

of a group of investigators and adjudicators versus every college trying to deal with it. It will strengthen for all colleges, but also for patients, to see that this is being dealt with in an independent way. This is not a dissimilar model from other things that go on. That may take a bit longer.

But I think patient support and access to services, including counselling, is really critical right now.

Mr. Robert Bailey: Do I have a little more?

The Chair (Mr. Monte McNaughton): One minute.

Mr. Robert Bailey: Okay, I'll wrap it up.

I was really disheartened when you said that a number of people—I can understand it when I think about it—who have been abused and have suffered have never re-entered the health care system. Would the amount of people who have never returned and had health programs be significant?

Ms. Sheila Macdonald: Yes. There's no trust and confidence in the system. There's no assurance that they're going to be safe when they come forward or that there are not going to be repercussions. To remind us all, as patients, of the vulnerability that we have when we see a health professional—with that trust being violated in a most personal, abusive way, they don't know where to go to next and who's going to do it next. They're afraid to come forward, so they won't go anywhere. It's terrible to have listened to patients who just will never come forward to get treated again.

The Chair (Mr. Monte McNaughton): We're going to move to Madame Gélinas now.

M^{me} France Gélinas: First, I'd like to thank you for the work that you did on that committee. Is there any way that you can share with us the recommendations that you shared with the ministry, that are at the base of the changes?

Ms. Sheila Macdonald: The 34?

M^{me} France Gélinas: Correct.

Ms. Sheila Macdonald: Some of the recommendations are in Bill 87—some of the changes that we recommended around expanding the definition of "patients." It's important that we understand that when a patient comes forward to a health professional, there needs to be a separation in that patient-clinician relationship. I think we had proposed two years, as I recall, and I think I see one year.

We expanded the definition of "sexual offences" because it's too limiting in the current act.

Am I getting to what you want?

M^{me} France Gélinas: Partly.

In the bill right now, we have one year post-last-visit, which is not defined. Had you defined it better—you had put two years. Is this what you're saying?

Ms. Sheila Macdonald: In the context of a therapeutic relationship, I'm not even sure there should ever be the possibility. When a patient comes forward and accesses long-term mental health service and support, where the patient is disclosing extensive vulnerable material about themselves, I don't think there should ever be the opportunity for a relationship.

Some of the recommendations are in the bill that's being proposed. There are many that aren't there, which I'm hoping are in the future plan. I've already alluded to some of them, around access to legal support.

M^{me} France Gélinas: In the bill it puts a time frame of five years for counselling and support. It can start right away. You don't have to wait for the guilty verdict. Is this something that you had recommended, and is this something you support? Because I could see some people who don't need support within five years, but two years later need some and then they're good, and then three years later need some and then they're good.

Ms. Sheila Macdonald: In the context of a therapeutic relationship with a patient, we learn a lot of the vulnerabilities of our clients, and so we should, because we need to in order to help them. To move that from the therapeutic relationship ending to a personal relationship—

M^{me} France Gélinas: No, no. I mean getting support for the victim. You've put in a complaint, and the bill says that you will have support for five years. I'm asking you, is it wise to put in the bill that you will have support for five years?

The Chair (Mr. Monte McNaughton): Madame Gélinas, I'm sorry, that's our three minutes.

Ms. Sheila Macdonald: I'm sorry. I didn't understand.

The Chair (Mr. Monte McNaughton): We're going to move to the government and Ms. Kiwala.

Ms. Sophie Kiwala: Thank you, Mr. Chair, and thank you very, very much for being here today, as well as for your past work that you've done on the task force. You've been a tremendous advocate for victims of sexual violence, and you continue to be so. We appreciate the work that you've done.

I just wanted to mention that the recommendations are publicly available on the Ministry of Health's website, so you can find them there.

I just wonder if you can speak a little bit about the impact that the amendments will have on Ontarians—if you could just elaborate a little bit more on that.

Ms. Sheila Macdonald: On the amendments in Bill 87?

Ms. Sophie Kiwala: Yes.

Ms. Sheila Macdonald: Yes, well, I think it will do a couple of things. I think it brings clarity to the definition of "patients." There were sexual abuse acts that were not included previously and should have been. We heard from many patients who told us and the advocates for them that it wasn't comprehensive enough, and all the acts are violating to patients. That's important, too.

I think the gender restrictions are not a good remedy in this situation. I think it's important. We need to uphold zero tolerance and send a very clear message to our patients and the public that it's not going to be tolerated and that we're not going to minimize through minimal consequences when somebody is perpetrating this behaviour. They don't belong in health care.

More than anything else, we put our patients in very vulnerable circumstances, so we need to be very, let's say, assured when we are exacting consequences for it. It's not okay. Minimal suspensions, signage, female patients only etc.—it's not appropriate. It just isn't.

Ms. Sophie Kiwala: I do also want to outline how you have brought forward very eloquently the catastrophic loss of faith that victims have in the system in general, and how that inhibits their going forward. I think it speaks to the government of how important it is to make sure that these measures do come forward.

How much time do we have left?

The Chair (Mr. Monte McNaughton): About 25 seconds.

Ms. Sophie Kiwala: Okay. Is there anything else that you want to add, just in terms of the importance of the measures of safety for Ontarians? Any last few pieces you would like to—

Ms. Sheila Macdonald: I think the one thing that will start, at least, the process of the public having confidence again is that we implement, more than these recommendations, the other recommendations. It is not just a singular approach. It's a good start, but we have some investment to do financially in supporting patients, and we need to seriously change our approach.

The Chair (Mr. Monte McNaughton): Thank you very much for your presentation today.

Ms. Sheila Macdonald: You're welcome.

ROYAL COLLEGE OF DENTAL SURGEONS OF ONTARIO

The Chair (Mr. Monte McNaughton): We'll now call upon the Royal College of Dental Surgeons of Ontario. You'll have six minutes for your presentation. If you would each state your name for Hansard, please. The questions afterwards will begin with the third party.

Mr. Irwin Fefergrad: Thank you very much, Chair and members of the committee. We're delighted by this opportunity to appear before you and let you know our general perspective. We'll only be speaking to schedule 4 of the statute, the Regulated Health Professions Act.

The Royal College of Dental Surgeons of Ontario is one of the oldest regulatory bodies, having been incorporated in 1869. We have the second-largest number of—

The Chair (Mr. Monte McNaughton): Sir, I'm sorry to cut you off. Would you confirm that you're Irwin Fefergrad?

Mr. Irwin Fefergrad: I was getting to that. I thought the college was first, and I ranked second.

The Chair (Mr. Monte McNaughton): Oh, okay. Sorry. We just want to make it accurate for Hansard.

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Mr. Irwin Fefergrad: Thank you, Chair. We have the second-largest number of controlled acts and authorized acts.

I'm the registrar. My name is Irwin Fefergrad. I'm not a dentist. I'm a lawyer, and I have a specialty in health law and in civil litigation.

I'm delighted to introduce you to Ms. Marianne Park, on my left, who is a public member of our executive and council, and on my right, Dr. David Segal, who is a member of the executive committee and a member of council. We'll each be speaking to you for a short amount of time, and we're delighted to take questions from you.

Dr. Segal.

Dr. David Segal: Thank you. My name is David Segal. With more than 35 years in dental practice, including hospital appointments, and experience as a council member in various capacities—and this includes being the vice-president and, as well, chair of the discipline committee—I have seen much change in our profession. I can assure you that the changes proposed in Bill 87 are important, and our college fully supports them.

At the RCDSO, we have a clear sense of our mandate: Our job is to act in the public interest by putting patients first. More transparency, as promised by Bill 87, is key. We did that in 2014, when we were the first college to put in place a transparency bylaw. By providing more information to the public, the people we serve get many benefits, including improved patient choice and increased accountability for regulators.

This openness and accessibility is vital for every area of our work, and it is of utmost importance when dealing with issues around sexual abuse of patients. That's why we are happy to support this legislation.

Thank you.

Ms. Marianne Park: Good afternoon, everyone. My name is Marianne Park. I have the privilege of being a public member with the Royal College of Dental Surgeons of Ontario, RCDSO.

I come to this field and this interest, particularly in this bill, from a lifetime of work in the violence-against-women field. I've been an advocate, a trainer, a researcher. I have the distinction of being a woman with a disability—I have low vision and albinism. I've also had the privilege of assisting in the regulation of six different professions, here in the province of Ontario, as a public member.

Presently, I serve on the executive. I also serve on the Inquiries, Complaints and Reports Committee, the ICRC. Indeed, I have served in the past on patient relations, and presently am on quality assurance.

I also represent the college on a task force out of McGill University which is designed to implement policies in the university setting, trying to eliminate or dismantle "rape culture," which of course is now a big buzzword.

It's interesting to note, though, with many of the processes that are suggested in the bill, that our college already has done that. There is support for the victim, from the reporting stage on. We have engaged experts in the field, such as Dr. Ruth Gallop and Dr. Sandy Welsh out of the University of Toronto, to assist us in

fashioning the very best possible way to support victims, including counselling and legal support. We've also done extensive training of staff around these issues, as well as producing practice advisories around sexual abuse and around boundary violations. In essence, I can't speak highly enough in support of the pieces that we are talking about.

Public members bring to the table a great balance. Now, very fortunately, with the college I'm presently serving with, it's transparent—the public members and the practitioners are integrated very well into all aspects of the college—and we do bring that balance.

I am here to speak not only on behalf of RCDSO but as an advocate, in support of the parts of this bill.

Mr. Irwin Fefergrad: Essentially, you heard that we unequivocally support the principles in the bill. It validates a lot of what we're doing around transparency. It validates what we're doing around eligibility to serve on committees, and the competence to serve on committee. As such, we feel the bill helps us do the work that we're required to do in acting in the public's interest.

I think I should stop there. I think that Dr. Segal and Ms. Park—

The Chair (Mr. Monte McNaughton): It's perfect timing because the six minutes is now up. So well timed.

Mr. Irwin Fefergrad: I saw the look, Chair, and I figured I'd better cut it off.

The Chair (Mr. Monte McNaughton): We'll move to Madame Gélinas.

M^{me} France Gélinas: Thank you so much for coming to Queen's Park.

My first question has to do with, in the bill, it sets a time frame of one year since the last encounter with patients. Is it clear to you when this one year starts ticking?

Mr. Irwin Fefergrad: What's clear to me in the bill is that it's quite brilliantly constructed where it says that the minister could develop regulations that would address what would be a patient. What is the definition of a patient? As you all know, we're all patients at one time or other. It's not so clear in our own minds. Is it when you call up and make an appointment? Is it, in a dental context, when you are sitting in the chair? And so we're encouraged when we read and it says that the minister is able to make regulations in that regard. We support that.

This ministry has been very consultative, not only on the opioid file, not only on human resource distribution, not only—

M^{me} France Gélinas: So right now, you don't know where the one-year clock would start ticking?

Mr. Irwin Fefergrad: We don't know, but we appreciate that the legislation provides for a discussion on that. We welcome that.

M^{me} France Gélinas: Are you satisfied with the one-year time period? Does that work for all of your members?

Mr. Irwin Fefergrad: For us, we hope we could influence the ministry that one year in dentistry is too short a period of time.

M^{me} France Gélinas: So you know that your college will continue to have the right to make it longer; it's just you won't have the right to make it shorter.

Mr. Irwin Fefergrad: Exactly.

M^{me} France Gélinas: You're satisfied with that?

Mr. Irwin Fefergrad: I can tell you we won't make it shorter. It will absolutely be longer.

M^{me} France Gélinas: Okay. When it comes to the time where the college has to support the victim, right now in the bill we're talking about from the time of complaint for a period of five years. Do you see a need, sometimes, to support victims longer than five years?

Mr. Irwin Fefergrad: Sure, and in our protocols that we have now, we're not restricted. We're not restricted when it starts. We're not restricted when it ends. So we actually support what's in the bill because we're doing it now.

M^{me} France Gélinas: But you want to continue to have the flexibility to have it start when you want, and have it end past the five years?

Mr. Irwin Fefergrad: We think we have it now. We're doing it now. I hope it's legal; don't tell anybody if it isn't. But I think that our council and our patient relations committee are invested in this. As I said earlier, the bill just really validates what we're already doing in that regard.

M^{me} France Gélinas: Right now, do you support victims who did not come to complain to you but you found out they were a victim of one of your members through the courts? Would you support them?

Mr. Irwin Fefergrad: That hasn't happened yet. I think the victim has to come forward. It doesn't have to be a victim. It could be somebody who accesses our process—

The Chair (Mr. Monte McNaughton): Thank you very much. We're going to move to the government and Ms. Malhi.

Ms. Harinder Malhi: Thank you for your presentation. You talked a lot about transparency in your presentation. Our government is committed to transparency and learning a little bit more about the medical regulatory colleges that exist, so that we can better understand and better serve. Would you be able to speak to some of the impacts that these changes, with the transparency and the changes that we're bringing forth in this bill, will have on patients?

Mr. Irwin Fefergrad: I think we're doing it all already. When you look at the requirements around, for example, council information, that's posted beforehand, including the materials. Our website provides council highlights within 72 hours of our council meeting. We have inspections in offices for sedation and for CT scans; the deficiencies get posted. There is really little that I can think of that is in the bill that we're not already doing.

The transparency file is not a closed file. Transparency is going to be an ongoing discussion. And there won't be less; there will always be more. We welcome that.

Ms. Harinder Malhi: Thank you. My second question is, we understand the importance of all the—

Mr. Irwin Fefergrad: Can you speak up? I'm hearing impaired a bit. I'm sorry.

Ms. Harinder Malhi: Sorry. We recognize all the important dental work that you do and the importance it has to Ontarians and to everybody here. We've also enjoyed an excellent working relationship with the dental college and dental professionals in Ontario.

How do you see the RHPA improving dental care for Ontarians?

Mr. Irwin Fefergrad: The RHPA, through the quality assurance program, through the requirement of assessments, through the requirement of courses, makes certain that we're able to say to the public that we measure each dentist in the competency arena.

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We also make sure that every complaint, as you know, is thoroughly investigated. While we're obligated to do it, we take that not as an obligation but as something that will help improve delivery of oral health care to Ontarians.

Ms. Harinder Malhi: Thank you very much.

The Chair (Mr. Monte McNaughton): No further questions?

Ms. Harinder Malhi: No.

The Chair (Mr. Monte McNaughton): Thank you, Mr. Yakubuski?

Mr. John Yakubuski: Thank you very much for joining us today. I think one thing is absolutely certain: We're all working hard and wanting to see sexual abuse at any level eradicated and dealt with if it does happen.

A couple of things that have been brought to our attention—and you seem to be very satisfied with the provisions in the bill. The section with regard to the medical records of a health professional and access to them: Are you comfortable that there are enough safeguards that an unwarranted look into the medical records of a health professional is sufficiently protected in this bill, or should something be more specified?

A second question, just in the interests of time: Are there no other amendments that you feel would make this bill stronger or things that should be corrected in the bill as it is written today?

Mr. Irwin Fefergrad: I'd like to see the bill passed quickly. To answer your first question, I think the minister has the authority now under section 36 of the RHPA, where there are confidentiality provisions—I think the minister, under number (b) in connection with the administration of the act, will relieve the confidentiality, and under section (i), where there is potential risk or harm to the public or to groups, the minister has the authority for us to be relieved of confidentiality. I'm not at all fussed about that requirement. I think the minister is being transparent and is saying, "Look, I want to make it clear that while I do have the authority under section 6, in certain exceptions I may actually use it."

I don't know the minister and I've never met him, but he is the chief health officer in the province, and he does have the responsibility, in my view.

Mr. John Yakubuski: So you say "certain exceptions"—under certain conditions or certain—

Mr. Irwin Fefergrad: I think it's already in the statute. I think that all the regulation does is lift out what the minister can already do and say, again, "This is what the minister can do." I think he can do it now.

Mr. John Yakubuski: Okay. Thank you.

Mr. Irwin Fefergrad: If he were to call me or—he wouldn't do it directly, but if somebody were to call me and say, "We need the health record of Dr. X because of," I think there's authority under the statute for me to deliver it now.

Mr. John Yakubuski: Okay. Thank you very much.

The Chair (Mr. Monte McNaughton): Great. Thank you very much for your presentation today.

FEDERATION OF HEALTH REGULATORY COLLEGES OF ONTARIO

The Chair (Mr. Monte McNaughton): We'll now call upon the Federation of Health Regulatory Colleges of Ontario. Good afternoon. You'll have six minutes for your presentation. If you'd begin by stating your name for Hansard, please. Questions will begin with the government after your presentation.

Ms. Shenda Tanchak: My name is Shenda Tanchak. I started working in the area of health regulation 22 years ago as a sexual abuse investigator at the College of Physicians and Surgeons of Ontario. By background and training, though, I am a lawyer. I went into that job with an absolute passion for patient protection but with years of training in due process of law.

From the very beginning, every time we improved our processes or made things better for patients, we heard that health care professionals would be forced to stop providing care for fear of unfair persecution. Although those alarms continue to sound today, they've never stopped providing care and the fears of unfair persecution have never really materialized.

I'm the registrar of the College of Physiotherapists of Ontario, but today I'm here in my role as president of the Federation of Health Regulatory Colleges of Ontario; we call it FHRCO. FHRCO represents 26 health colleges. We regulate 300,000 health professionals in Ontario.

I'm genuinely proud to speak on behalf of the federation in support of enhancements to the protection of patients against sexual abuse by health care professionals, and to ensure that all patients have access to the information they need to empower them to make choices about their own health care.

With respect to the transparency provisions in Bill 87, as Dr. Segal from the RCDSO mentioned, we colleges already publish most of the information required under the bill. Well before any legislative amendments were drafted, the colleges of FHRCO, led by a subset called the advisory group on regulatory excellence, adopted transparency principles. Together, all of the colleges circulated those principles to our 300,000 members, and we asked them what their concerns were and whether

they supported the changes that we were making. We took the results of the consultation back to our respective councils. Balancing the feedback of the professions and the needs of patients, each college adopted and implemented the transparency principles and the bylaws that were required to enact them.

That means that information about criminal charges, cautions, specified continuing education and remediation orders, and details about referrals to discipline have been published already by some colleges for as long as two years, and portions of different subsections of that information have been on public registers for longer than that. Working together without legislation, Ontario's health care colleges—and, it's really important to note, the professions that we regulate as self-regulating colleges—have made Ontario a world leader in transparency in health regulation.

You should also know that FHRCO, the colleges, have worked together to develop a website intended for patients that will launch at the end of this month and will give patients one single website to go to when they need information about how to make a complaint about a health professional or where to find a particular health professional.

That goal, that aspiration of transparency, is a work in progress. We're really pleased to see it codified in Bill 87, to give us the reinforcement we need to keep going in this direction. So much in Bill 87 will support us to achieve our common goals of patient protection and due process for the professions that we regulate.

We see some opportunities for the legislation to go even further to protect the public interest. There are a handful of examples in the submission that we circulated to you, but I'm just going to mention a couple to give you the gist of what we mean.

As I said, many of us are already publishing information about criminal charges on our public registers, but there isn't any official channel by which we receive this information. As the registrar of a college, I might hear from a patient or I might hear from an individual police officer about a criminal charge laid against a professional. If the Attorney General were required to report to the colleges this kind of information, not only would we have some information that we might need to investigate, but we could put that on the public register. This is information that could be very valuable to patients making decisions about what health care practitioners to see.

Another example of how Bill 87 could go even further to protect the public interest is to broaden the amount of information the colleges can tell the public about investigations that are under way. Right now, as we understand the Regulated Health Professions Act, we can acknowledge that there is an investigation, but we can't provide further information, so it could go a little bit further to allow us to disclose information where it was in the public interest to do so.

There are ways the bill could go further, and then we do have some concerns about the bill. They are described

in detail in the written submission. We're presently in discussions with government about how we might work together to make amendments and fill the gaps, and we're looking forward to further consultation on that. I'll give you a couple of precise examples about that.

The amendment that is intended to increase access to funding for victims of sexual abuse: You've been talking a little bit about that already. I think, as Mr. Fefergrad said—

The Chair (Mr. Monte McNaughton): That's the six minutes. We'll move to the government. Ms. Kiwala?

Ms. Sophie Kiwala: If you want to take just a couple of seconds to finish anything up?

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Ms. Shenda Tanchak: I was just going to say that some of the provisions in Bill 87 are a little narrower than what the colleges are already providing to victims.

Thank you.

Ms. Sophie Kiwala: The one thing that I do want to start out by saying is just acknowledging you for your very collaborative approach that you have used in dealing with the subject. You personally have worked on this subject for over two decades. That's pretty impressive. Well done.

I want to also mention that I think it is that collaborative approach that we very much appreciate. We have benefited from your expertise in the field, and we continue to look forward to working together with you. So we thank you for that.

I'm wondering if you could elaborate a little bit on the impact that the changes will have on Ontarians as they seek necessary health care services in the future.

Ms. Shenda Tanchak: I think the transparency provisions make a very important difference. I think that empowering patients to make informed decisions about the health care providers they wish to see is the best thing that we can do. Acknowledging that they not only have a responsibility, but that they're very capable of assessing the information they can find on the public register, is the first step in working really as partners with patients.

Ms. Sophie Kiwala: Again on the collaborative piece, sending your consultation out proactively to 300,000 members is very good—and developing the website as well. Those steps that you've taken to be ahead of the game—you're not just looking at what you are presented with. Your looking at how to prevent situations in the future is highly commendable.

I'm wondering if you can talk a little bit about how you see these measures improving patient care and the integrity of the medical profession.

Ms. Shenda Tanchak: I've talked a little bit about transparency. If I turn to the sexual abuse provisions, I think that we will enhance public trust in health professionals by demonstrating support, of course, to victims who come forward, but also clearer direction to our members about what is allowed or not allowed.

For example, in the vernacular, that one-year "cooling-off" period: That turns on how we define "patient." I think that some of the others who have spoken

today have talked about how what's okay in one situation is really not in another. If a radiologist looks at—

The Chair (Mr. Monte McNaughton): Thank you very much. We're going to move to the official opposition, and Mr. Yakabuski.

Mr. John Yakabuski: Thank you very much, Ms. Tanchak. I appreciate the submission. Bearing in mind that we only receive this seconds before you start speaking, I haven't had time to read ahead and see some of your recommendations, but we will be passing these on to our health critic, Mr. Yurek, and looking at them carefully.

You did make a couple of comments about things you'd like to see expanded on. One was to broaden the information that could be released on a case from the respective college. Is that what you're talking about?

Ms. Shenda Tanchak: That's right, yes.

Mr. John Yakabuski: And also, there should be a provision that if someone has reported a case of abuse, there should also be a return of that information from the Attorney General's office to the college, full disclosure, so they have access to the same information that the legal system is having. Am I reading that correctly?

Ms. Shenda Tanchak: I wasn't limiting it only to sexual assault charges, but to all criminal charges, and not necessarily a ton of information, but just the fact that the charges have been laid.

Mr. John Yakabuski: Okay. So at this point, is it possible that a member of the college could be charged with a criminal act, possibly sexual abuse, and the college would not be aware of it?

Ms. Shenda Tanchak: Very possible.

Mr. John Yakabuski: Very possible. Yes, that would be something that should almost come as second nature. If a member of the college has been charged with something, and the legal system is aware of it and our justice system within the province is aware of it, then in order for the college to act—because it's not just the legal system that could enforce penalties on someone who is found guilty; the college itself is expected to. If it becomes in the public domain, it may filter down to you. But I think you're right: A direct passing-on of that information would be appropriate.

I didn't have time to read all of them. Broadening the information on a particular case—can you expand on that a little bit?

Ms. Shenda Tanchak: I'm not sure I remember exactly what I said that triggered that question.

Mr. John Yakabuski: It was going fairly quickly.

Ms. Shenda Tanchak: Yes, sorry.

Mr. John Yakabuski: Anyway, I appreciate you coming in today. We will take a look at the entire submission.

Is there a specific amendment that you think we should be looking at very closely, that is of most importance to you?

Ms. Shenda Tanchak: There's probably a handful, so I'm not saying it's most important, but the definition of the acts for which mandatory revocation would be the

penalty may be unnecessarily confining. There are equally horrible things that can happen to patients that this shopping list doesn't address. I think we genuinely all want increased protection, but there may be different ways to achieve it.

Mr. John Yakabuski: Have you submitted a suggested amendment in your package here?

Ms. Shenda Tanchak: We've addressed that issue, and we have been talking to government about some of this.

The Chair (Mr. Monte McNaughton): We'll move to the third party. Madame Gélinas.

M^{me} France Gélinas: You talked about the increased power to the minister and the power to make fundamental changes to the very essence of self-regulation. Give me an example of what this could look like, the way that the new powers will be after Bill 87.

Ms. Shenda Tanchak: It's a bit of a fantasy world, because we don't really know what the exact intention is. But as we understand it, this provision is broad enough that the minister could decide that no more regulated health professionals should sit on statutory committees, which would undermine the meaning of self-regulation. So without further information about the intention, we can't say, but of course then you speculate.

M^{me} France Gélinas: I fully understand. Part of the bill also says that the minister can compel a college to provide reports and information that may contain personal health information about a member. You're comfortable with this?

Ms. Shenda Tanchak: Yes, I am. I think that is, again, building on what Mr. Fefergrad said. We don't have any reason to think that these requirements would be used without discretion. We think the minister could already do that. Certainly, the minister has the power to appoint a supervisor today. It is our belief that that has been out there all the time and hasn't been used indifferently.

M^{me} France Gélinas: The bill also sets a time frame of one year after—something that is not clear to me. Is it clear to you when the one-year clock starts ticking?

Ms. Shenda Tanchak: Yes and no. The problem is in the definition of "patient." If I am a radiologist and I look at one X-ray, do I wait a year before I can date that person I've never met? I think I understand when the one year starts: It's the last day I look at that X-ray.

The problem is not the one year; the problem is the definition of "patient." A psychotherapist should never, ever be allowed to enter into a personal relationship with a patient. That one year might make it look as though that was all right with the government.

M^{me} France Gélinas: Is it your understanding that colleges will be free to set time frames that are longer than one year?

Ms. Shenda Tanchak: I believe there will be flexibility. Again, it's not entirely clear. As well, how "patient" will be defined is not entirely clear. Those are conversations that we'd like to continue to have.

M^{me} France Gélinas: Those are a big piece, eh? If we don't know what the definition—I agree with you. I hate it when everything is left to regulations, because we get to vote on a bill that could mean very different things.

It's the same things for victims to have access to support—

The Chair (Mr. Monte McNaughton): Madame Gélinas, that's all the time.

Thank you very much for your presentation today.

Ms. Shenda Tanchak: Thank you.

The Chair (Mr. Monte McNaughton): For the folks standing at the back, I just want to let you know that there are quite a few chairs if you'd like to have a seat. Maybe people could shift down a bit to let others in.

ONTARIO NURSES' ASSOCIATION

The Chair (Mr. Monte McNaughton): We'll now call upon the Ontario Nurses' Association. You'll have six minutes for your presentation. Please start by stating your name for Hansard. The questions, this time, will begin with the official opposition.

Ms. Vicki McKenna: Good afternoon. My name is Vicki McKenna. I'm a registered nurse and the provincial vice-president for the Ontario Nurses' Association. Joining me today is Sheila Riddell, ONA's manager of our legal expense assistance plan—and working with our regulatory bodies on behalf of our members.

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We have three primary concerns with Bill 87, schedule 4, that I'll present this afternoon. First of all and most problematic for ONA members is the requirement that colleges post on their registers results of all discipline committee and fitness to practise hearings, even when there has been no finding against a member. Second, ONA is also concerned with the proposal that the Inquiries, Complaints and Reports Committee, the ICRC, be given the authority to issue interim suspensions at any time just after a complaint is filed. Finally, ONA is concerned with the definition of "patient" with respect to sexual abuse—the one-year definition—given the serious mandatory consequences for sexual misconduct.

Let us move on to our primary issue. Currently, the results of decisions from the discipline committee and fitness to practise committee are posted only if there is a finding against a member. The proposed amendment in section 12(1)(2)10 states that all results will be posted, while section 12(7) makes it clear that the result includes, among other things, the failure to make a finding.

This proposal is harmful because even in a situation where a nurse is cleared of all allegations, the record of the allegations and the hearing will remain publicly available. In theory, the no-finding decision may exonerate the nurse; however, there still will be the taint of the accusation that attaches to the posting of this information, an assumption in the minds of some members of the public that the nurse must have done something wrong. This is exacerbated by the fact that the discipline panel does not release a finding of "not guilty"; it releases a

decision of "no finding," which may, to lay members of the public, not necessarily equate to innocence.

Posting these decisions will cause personal humiliation and embarrassment to Ontario's nurses and, more importantly, will hurt their career prospects: We often hear from nurses that negative information on the register makes it very difficult for them to find work and may often limit their career paths.

This is particularly problematic with respect to fitness to practise decisions. If a nurse has a contested fitness to practise hearing and is successful, and providing that they are not incapacitated, there will be a decision on the register that says: "not incapacitated." This decision will remain on the register for a minimum of six years because of other provisions of the RHPA, section 23(11). The very fact that the public will know there was an incapacity hearing increases and carries a stigma because these hearings always relate to mental health issues.

It is ONA's position that this part of Bill 87 violates the Ontario Human Rights Code, which prohibits discrimination based not only on disability, but on perceived disability. ONA proposes that the current practice continue, posting discipline and fitness to practice results only when a finding has been made.

We'll now move to our second area of concern. Under current practice, the ICRC can impose an interim suspension on a member after it refers the matter to the discipline committee. Matters only get referred after an investigation is complete and the nurse has received full disclosure and an opportunity to respond.

The proposed amendment in section 15 gives the ICRC the ability to impose an interim suspension at any time after the complaint is received. The ICRC can do this if they consider the conduct of the member or the member's physical or mental state to be likely to expose a patient to harm. The member will receive notice of the intention to make the interim suspension and will have 14 days to respond.

This provision is problematic because it will result in an increase in interim suspensions in situations where the ICRC has not even received submissions. While the provision does allow 14 days for the member to respond, it may be meaningless without any sort of investigation or disclosure of documents. This puts members at risk of being deprived of their ability to earn a living without any of the protections of procedural fairness.

Our third concern relates to the proposal in section 7 regarding sexual abuse provisions that define "patient" as someone who was the member's patient within the last year, or a longer period as may be prescribed. ONA finds the one-year definition to be an arbitrary and unreasonable requirement. Nurses in certain fields are regularly in situations where they provide care to a patient only once and only in a fleeting therapeutic relationship, such as an emergency triage nurse or a relief nurse who relieves a peer for a coffee break.

The penalty for a finding of sexual abuse of a patient is extremely serious and is mandatory once the finding of fact is made: either revocation or suspension, depending

upon the specifics of the conduct. Given the seriousness of the consequences, an arbitrary one-year definition regarding who is a patient seems inappropriate. It does not allow a discipline panel to tailor the punishment to the misconduct by considering the type of care and the length, intensity and nature of the therapeutic relationship.

To conclude, we also have three additional comments regarding the minister.

First, the minister presently has the power to ask the college council about the state of practice of the profession, review the council's activities, and require the council to make regulations. The proposed amendment in Bill 87 under section 2 will allow the minister to also ask council about personal information and personal health information of the member of the college to determine whether the college is fulfilling its duties.

We find this proposed provision to be intrusive. First, it allows the minister to be overly involved in respect to how the college deals with individual health inquiries—

The Chair (Mr. Monte McNaughton): Thank you very much. That's all the time for the presentation.

Ms. Vicki McKenna: All right.

The Chair (Mr. Monte McNaughton): We'll move to the official opposition and Mr. Yakabuski.

Mr. John Yakabuski: Thank you very much, Ms. McKenna, is it?

Ms. Vicki McKenna: Yes.

Mr. John Yakabuski: I've got to get my glasses on. Yes, Ms. McKenna and Ms. Riddell.

I'm not the critic on this file. I was kind of pressed into service on an emergency basis. I just want to get something clear based on the objection that you've raised here.

Under this legislation, assuming someone was a triage nurse and they had almost instantaneous contact with a patient, and eight months later, they happen to meet in an unrelated way and there's a conversation—"Oh, my goodness, you came into the emerg in such and such a hospital"—and within the one-year period, they actually begin a relationship, that nurse could be guilty of sexual abuse under this law?

Ms. Vicki McKenna: I'll let Sheila answer that.

Ms. Sheila Riddell: Yes, our reading of it is that that nurse could be guilty of sexual abuse if they engage in any of the laundry list of activities. The problem is that, if those activities are engaged in, depending on what the activities are, the penalty is mandatory; right? So the discipline committee has no discretion about what the penalty is going to be once there has been a finding of fact about the acts. It's going to be either suspension or, in many cases, a mandatory revocation of that member's licence.

We could find a nurse who completely loses his or her licence to practise because of some sexual act with someone who is a patient but in the most momentary of ways: Somebody who came into triage, maybe, and the nurse saw that they needed stitches, wrote a few things on a form and sent them on their way.

To us, the fact that there's already no discretion about the penalty is one thing. We understand the reasons in terms of the protection of the public. But to also extend for an entire year the definition of what a patient is in every circumstance just seems extremely harsh.

Mr. John Yakabuski: So maybe a more clear definition of what a patient is and who qualifies as a patient?

Ms. Sheila Riddell: And that may be the case, and I think that some of the folks who have just been up here speaking in the last half-hour have made reference to that.

Mr. John Yakabuski: Okay. I have to be honest with you, I wasn't aware of the potential of that. But it seems to be, assuming there was no other contact whatsoever and it was almost accidental and the nurse may not even be aware of when the actual contact was—it could have been a year; it could have been eight months—

The Chair (Mr. Monte McNaughton): Thank you very much, Mr. Yakabuski.

We'll move to the third party and Madame Gélinas.

M^{me} France Gélinas: Continuing on this topic, are you able to bring forward a definition of "patient" that would protect both the nurse who has an incidental patient relationship versus the protection of a victim of sexual abuse? Are we able to find a "patient" definition that meets that?

Ms. Vicki McKenna: Sheila will add more, but we believe it's the fleeting interaction with a triage nurse or someone giving a quick coffee break to someone who really isn't in the circle of care for a real length of time, where they really don't have that relationship that develops.

We certainly support the bill trying to address the issue. There are very serious issues around sexual abuse, absolutely. But I think the definition of "patient" for a triage nurse, as opposed to someone who has a long-term-care relationship, a therapeutic relationship with a patient—it's really quite a different interaction. I don't know if Sheila could define it any more. I think we could define the fleeting moment or the episodic easier, maybe, and leave it to others to define the more lengthy relationship.

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Ms. Sheila Riddell: I think it's something that definitely requires more thought, but I think that when you look at the purpose behind these changes, behind any of these provisions about sexual abuse, it's to protect patients because they are vulnerable, because they have developed a trusting and fiduciary relationship with a health care provider. When that has never had an opportunity, really, to happen, I think that's the problem.

M^{me} France Gélinas: Okay, and you haven't seen the definition of "patient," so we're all assuming that it could include a triage nurse, it could include—

Ms. Vicki McKenna: Yes, as we see it, yes.

Ms. Sheila Riddell: That's our worry, in terms of our members, yes.

M^{me} France Gélinas: Okay. The part about the ministry being able to ask for personal health information of

a member: Can you think of a reason why the minister would need that information?

Ms. Vicki McKenna: No.

Ms. Sheila Riddell: We can't. That's the trouble. It does just seem to leave itself open to abuse, given that at the moment there are no criteria, no limits on when that power could be invoked.

M^{me} France Gélinas: If you were to put limits on it, where would the limit be?

Ms. Sheila Riddell: I don't know that I can answer that on the spot. I guess all I would say is that we're worried that there is not going to be the respect for the privacy of nurses' personal health information, in the way that nurses are constantly aware of the protection of their patients' personal health information. We think, certainly, there needs to be some recognition of that, especially given that this is already the—

The Chair (Mr. Monte McNaughton): Thank you very much. We're going to move to the government now, and Mr. Fraser.

Mr. John Fraser: Thank you very much, Mr. Chair, and thank you very much for being here today. I want to relate to one of the last things you said. We are focusing on individuals that are vulnerable because of the relationship that exists, and we could all appreciate that. I think we've done a lot to work together to do a lot of things to protect patients in other circumstances, but these are particularly serious.

As far as consultation with regard to the RHPA, can you describe what's happened between yourselves and the government, in terms of looking at the RHPA?

Ms. Sheila Riddell: Well, I know that we have had some meetings with—Mr. Chesney, I believe?

Ms. Vicki McKenna: Yes.

Ms. Sheila Riddell: —to discuss our initial thoughts on this and to present him with some of our concerns.

Ms. Vicki McKenna: Yes, and we have a formal submission, which you should have before you as well.

Mr. John Fraser: Thank you. One of the things when we're talking about this particular situation—which is really serious, and I think we all look on this as something that needs to be addressed—is that as you're trying to strive and achieve a balance, there's also a need for transparency and confidence from the perspective of the public. I can see what you're saying.

Can you speak to how you see that transparency? I know you expressed some concerns about what was posted, but how do you get that balance of transparency where you have a situation that—you know?

Ms. Vicki McKenna: Primarily, first off, one of our significant issues with the posting is that there's a posting of an allegation, and even if the process continues throughout and there is to be "no finding"—which really is "not guilty" in the world of the courts, but in the world of the college of nurses, it's "no finding"—it still appears there and stays on the register, in the forefront, under "Find a Nurse" on the website for six years, for "no finding."

For the public to do a search under "Find an Nurse" and to look for an individual nurse and see this and see there's no finding—I don't believe that the public would understand that that means that the person was innocent, that they were found to be not guilty, although the college does not use that wording. It's not the court system; it's different. That's a problem for us.

Ms. Sheila Riddell: If I could just add one thing, I think we're especially concerned in terms of the fitness to practise hearings, because transparency is all well and good, but that obviously has to be balanced against the human rights of nurses. They are also members of the public, and for there to be information that essentially reveals a disability, and there's no disability that carries more stigma than mental health and especially addictions—

The Chair (Mr. Monte McNaughton): That's all the time we have for your presentation and for the questions. Thank you very much for presenting today.

COLLEGE OF RESPIRATORY THERAPISTS OF ONTARIO

The Chair (Mr. Monte McNaughton): We'll now call upon the College of Respiratory Therapists of Ontario. Good afternoon. You'll have six minutes for your presentation, followed by three minutes of questioning, beginning with the third party. If you'd just state your name for Hansard, please.

Mr. Kevin Taylor: Sure. Good afternoon. My name is Kevin Taylor. I'm the registrar at the College of Respiratory Therapists of Ontario.

Mr. Chair and members of the committee, thank you for the opportunity to make a submission today on the proposed amendments to the Regulated Health Professions Act that are found in schedule 4 of Bill 87, the Protecting Patients Act.

The College of Respiratory Therapists of Ontario is one of the 26 regulatory colleges which govern health professions under the RHPA, and is responsible for regulating the profession of respiratory therapy. We are a relatively small college, with approximately 3,500 RTs currently registered with us. The area of expertise for this profession is the treatment and management of cardio-respiratory disease, with most patients having a relatively high degree of acuity.

Most RTs work within the acute-care setting of hospitals or other health care organizations and rarely as sole practitioners. As a result of the nature of their practice and the practice settings in which they work, the CRO actually—fortunately—receives very few complaints or reports relating to sexual abuse or sexual misconduct.

But that said, we do feel that this is an important issue and wanted to speak in support of the intent and goals of Bill 87 in striving to provide the strongest measures to support patients and prevent sexual abuse. As a college, we have long held a zero-tolerance stance on this topic, and are continually seeking ways to improve our own practices in this regard.

We endorse expanding the definition of sexual abuse for which a health professional's licence would have to be revoked. As with other colleges, however, we worry that the list in the bill may leave out other equally egregious behaviour, and recommend that there may be value in looking at expanding the definition through a different approach than just a list.

Further, we're grateful for the provision in the bill which would prevent a practitioner from working, once he or she has been found guilty of a revocable offence. In fact, an expansion of this provision beyond cases of sexual abuse would be a welcome addition to the bill.

Similarly, we endorse the notion of defining "patient," yet, recognizing that the circumstances under which patients and practitioners interact can vary widely, feel that a list of relevant criteria, developed to assess each unique circumstance, would be more effective than a one-size-fits-all definition.

Along with many other colleges, we've made great progress in increasing the amount of information available to the public about respiratory therapists. We already make most, if not all—in fact, I believe we have all—of the information listed in Bill 87 currently available to the public, and have gone further by including information that is not currently required in the proposed amendments—information such as relevant pending charges, bail conditions and convictions. Adding these to the bill would help to ensure consistency across all colleges, something that we believe would be of benefit to the public.

We should note, however, that obtaining this information is not without challenges. It is commonly self-reported information, and even identifying which court to approach to obtain transcripts can sometimes be laborious. As such, it would be tremendously helpful to also require the Attorney General to promptly notify colleges of these events when they relate to registered practitioners.

We are also in support of the expanded ability to disclose information to regulators of long-term-care homes. The aging population, and the concurrent rise in the prevalence of chronic respiratory disease, makes this care setting one that will see more clinical activity from RTs in the future than occurs currently, making this an area of particular interest for us.

We would encourage the government to go further with this amendment, permitting disclosure where, in the opinion of the registrar, there is a compelling public interest in the disclosure of that information. Considering recent examples from the media, this would allow the colleges to disclose where appropriate, to assist in maintaining public confidence in the current regulatory model in Ontario as well.

In closing, I would like to emphasize that the CRTO supports the objectives of the proposed amendments within Bill 87 and is thankful for the opportunity to contribute to the process, to ensure that the public is protected and that the public interest is served.

Thank you.

The Chair (Mr. Monte McNaughton): Thank you very much. Madame Gélinas?

M^{me} France Gélinas: Right now, within your college, how do you describe what sexual abuse is? You don't use a list, I take it?

Mr. Kevin Taylor: No, we don't. I must admit, we have very little experience with it because we just don't get that nature of complaints.

I don't think our definitions would differ from, really, anyone else's. Where we have activity that's sort of on the fringe, that's not quite clearly abuse, I think we'd have to rely on our legal opinions and draw on some advice from our colleagues, because it would be new territory for us.

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M^{me} France Gélinas: But you do say that you would like to see something else other than just the list. What did you have in mind when you made that comment?

Mr. Kevin Taylor: I think bad people find ways to work around restrictions. If you give a defined list, they will start to find ways around the outside. As an alternative, perhaps a list of criteria that could be applied in all settings would be more effective than trying to define—there will always be exceptions, so I think every time you try to pin down something like that, you run the risk of opening the door to something else.

M^{me} France Gélinas: So a list plus other criteria that would—

Mr. Kevin Taylor: Actually, that would be not bad.

M^{me} France Gélinas: For creativity.

Mr. Kevin Taylor: Yes.

M^{me} France Gélinas: I take it that the one year or more as a definition of "patient"—do you have ideas in mind? I think of a respiratory therapist who is called in at midnight because the respirator is not working well, and they do what they have to do, and they never see the patient again, and they never really interacted with the patient that much. A year later, they may not even remember. How does that work for you?

Mr. Kevin Taylor: Again, I think the definition of "patient" is going to be key in this. Our profession is no different than many others in that there is a range of types of practice. A momentary interaction is going to be very different than a prolonged professional relationship you may have in a chronic care facility. I think there has to be a minimum, but I think there needs to be discretion to allow that time period to be extended to account for that variance in circumstances.

M^{me} France Gélinas: Do you have language right now that you would like to see in the "patient" definition that would make sure that we don't capture a one-off encounter like fixing the respirator versus—

The Chair (Mr. Monte McNaughton): Madame Gélinas, that's the three minutes.

We'll move to the government. Ms. Kiwala.

Ms. Sophie Kiwala: Thank you very much, Mr. Taylor, for being here, and thank you very much for the work that you do. I have a brother who has COPD, so he is in very frequent contact with respirologists, and I well

understand what a very critical and vulnerable community of patients you represent. While you are a relatively small college, you're looking after a very, very vulnerable group of patients, and I respect and acknowledge you for that.

This group of patients has a very high rate of revisiting medical professionals and a very high rate of needing emergency medical services, so the contact that your patient group is going to have with the medical system in general is probably going to be very extreme compared to some of the other colleges. Considering that, I'm wondering if you can speak a little bit to the impact that these changes will have on Ontarians as they seek medical care in the future.

Mr. Kevin Taylor: I think it's important to recognize that the practice of health professionals, and respiratory therapists in particular, is never in isolation. It's in conjunction with society as a whole. Elevating the level of professionalism or the stringency of the requirements for someone to behave as a professional, I think, is a rising tide that raises all boats. By elevating the standards for accountability and professionalism, if you will, for all professions—I think there's a trickle-down effect where the expectations of society rise, and then what becomes socially acceptable and socially unacceptable also evolves with that.

I believe that the provisions within this bill are the start of something that could lead to large-scale change.

Ms. Sophie Kiwala: Can you also speak to how the RHPA will help Ontario's respiratory therapists and our government to continue to work together to deliver the best possible care to Ontarians?

Mr. Kevin Taylor: Perhaps I'll echo my previous comment in that I believe that by strengthening or raising the level of expectation for professionals, you raise the quality of care, you raise the expectations of patients, and you raise the expectations of the professionals themselves to be able to provide better care.

Ms. Sophie Kiwala: Did you have anything else that you wanted to add?

How much time do we have?

The Chair (Mr. Monte McNaughton): Eleven seconds.

Ms. Sophie Kiwala: Eleven seconds.

The Chair (Mr. Monte McNaughton): Not that anyone is counting.

Mr. Kevin Taylor: No, thank you.

Ms. Sophie Kiwala: Thank you very much for being here and for your work.

Mr. Kevin Taylor: My pleasure.

The Chair (Mr. Monte McNaughton): Thank you very much. We'll move to the official opposition—three more minutes for you.

Mr. Bailey.

Mr. Robert Bailey: Yes, we're not letting you get away that quickly. Thanks for your presentation.

You've answered most of the questions, I think, from the other two parties.

I did want to know about something you had in your third or fourth paragraph. We had talked about preventing a practitioner from working "once he or she has been found guilty—in fact, an expansion of this provision...." Could you elaborate on that in the time you've got left? What do you mean by—

Mr. Kevin Taylor: Sure. It's more of a principled comment based on process. Imagine that the panel has just made a decision. There is then a period of time where they go away, they write the decision, it gets reviewed and it's submitted. Only then is it approved by the panel and then submitted to the member, and penalties are exercised at that point. That time period is, I think, the time in question.

If anybody has committed a revocable offence, it would seem reasonable that someone should not be permitted to practise during that period, until the administrative elements catch up with the actual decision.

Mr. Robert Bailey: Okay. So that's kind of what you were referring to.

Mr. Kevin Taylor: Exactly.

Mr. Robert Bailey: Okay. That's all I have.

The Chair (Mr. Monte McNaughton): Okay, great. Thank you very much.

Mr. Kevin Taylor: Thank you.

Mr. Robert Bailey: Unless there's something you want to—

Mr. Kevin Taylor: No, I'm good.

Mr. Robert Bailey: All right. You've said it all.

The Chair (Mr. Monte McNaughton): Okay. Thank you very much for your presentation.

Mr. Kevin Taylor: Thanks, all.

ONTARIO ASSOCIATION OF NON-PROFIT HOMES AND SERVICES FOR SENIORS

The Chair (Mr. Monte McNaughton): We'll now call upon the Ontario Association of Non-Profit Homes and Services for Seniors. Thank you for joining us this afternoon. You have six minutes for your presentation. Questions afterwards will begin with the government. If you'd just state your name for Hansard, please.

Ms. Cathy Gapp: Hi, my name is Cathy Gapp. I am chief executive officer of the Ontario Association of Non-Profit Homes and Services for Seniors, known as OANHSS. With me today is Shilpi Majumder, our director of policy.

OANHSS is a membership association. For close to 100 years, we have represented municipal, charitable and not-for-profit long-term care, seniors' housing and seniors' community service providers across the province. Our comments today will be focused on the Seniors Active Living Centres Act, schedule 5 of Bill 87.

We were very pleased to see the reintroduction of the Seniors Active Living Centres Act into legislation that would replace and modernize the existing Elderly Persons Centres Act. Elderly persons centres operate as an important component of the continuum of care offer-

ings in communities. Many of our long-term-care members are redeveloping their homes, and the existing buildings offer an opportunity for repurposing and providing community services and possible sites for future seniors active living centres. Many of our members offer innovative programming to their residents, and these could be expanded to be offered to community-dwelling seniors.

We are appearing before you today to express our concern that the proposed act does not continue the current requirement in the Elderly Persons Centres Act for approved operators to be not-for-profit or charitable corporations.

We are aware that municipalities must put forth 20% of the cost to operate a centre. However, we believe that by not continuing the requirement that a centre be operated by a not-for-profit entity, unnecessarily a door opens to allow scarce government program dollars to be diverted away from operating seniors active living centres. In addition, by not specifically stating the requirement for a not-for-profit centre, future interpretation would allow otherwise.

We understand that the removal of the requirement from the proposed act is to provide more flexibility, to allow the First Nations organizations to participate as seniors active living centres, and to allow in-kind contributions to not-for-profit organizations. We totally support the intent. However, we believe these specific allowances can be made without removing the requirement that an operator of a seniors active living centre be a not-for-profit organization.

Dr. Shilpi Majumder: OANHSS recommends that the proposed Seniors Active Living Centres Act be amended to continue the current requirement that ensures that a seniors active living centre operator must be a not-for-profit entity. This amendment will serve to protect the not-for-profit sector, to ensure that government funding is used to support high-quality programming for seniors. Evidence shows that not-for-profit providers provide high-quality and more accessible programming as all funding is allocated fully to provide high-quality programming and services, and any reserve funds are used to expand and enhance existing services.

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Not-for-profit organizations are deeply rooted in and accountable to their communities and designed specifically to meet local, cultural and spiritual needs. A variety of innovative programs are provided by not-for-profit campuses of care, including day programs, caregiver education, respite care, fitness programs, drop-in centres, music therapy and many others to enrich seniors' lives and help them remain at home for as long as possible.

We urge the government to amend the proposed act to re-establish the not-for-profit criterion for the approval of programs and services. Our members appreciate the opportunity to expand and enhance their services to seniors in the community. They have the experience and expertise to provide services that meet local needs. They

are also recognized for their effective use of scarce resources. We urge you to continue the practice of maintaining these and future centres as not-for-profit.

Thank you for your time and this opportunity.

The Chair (Mr. Monte McNaughton): Thank you very much. We'll move to the government to begin this round of questioning. Mr. Fraser.

Mr. John Fraser: It's very nice to see you this afternoon. Thank you for being here. This is a bit of an aside: I have an elderly persons centre at the Heron Road multi-centre in my riding of Ottawa South. I also have the Council on Aging of Ottawa. They really do some great work.

I'm going to add one more thing: I somehow got my first senior's discount because, I guess when you're over 55, there are places—so it was kind of an honour and a trauma at the same time. I did save about 30%—so we're all going there.

I think as we go forward, collaboration in communities and people coming together around an outcome is a way forward. There is a limited amount of dollars out there. How do we see your sector in terms of what's happening with this legislation moving forward in that way, with things like community hubs, universities and other interested partners? I understand what you were saying in regard to the changes you want made in the bill, but I'm a bit more interested in how you see that coming together.

Dr. Shilpi Majumder: We also have a number of long-term-care homes that our members are redeveloping. As they're redeveloping, their existing buildings are now available, and they are certainly considering expanding their partnerships and providing that community care. Some of those may possibly become seniors active living centres. That is one avenue whereby our members are expanding their expertise out into the community.

Many of our other members, as well, are looking for that opportunity to provide their services out into the community. This would be one avenue to do so.

Ms. Cathy Gapp: We also are very strongly in support of seniors' hubs and seniors' campuses. We see the whole continuum of housing and community services and programs functioning together in partnership. That's our vision for the future.

Mr. John Fraser: Yes, I think that's critical. The Perley and Rideau Veterans' is in my riding of Ottawa South. They are further developing programs. They've got some supportive housing as well. It's kind of mixed. It's not quite co-op but it's around that kind of idea, next to a long-term-care facility. They're now looking at ways of actually bringing the community in. I think that's kind of a critical piece as we go forward, to make sure that we enable that happening.

Ms. Cathy Gapp: We agree.

Mr. John Fraser: Thank you.

The Chair (Mr. Monte McNaughton): Great. We'll move to the official opposition and Mr. Bailey.

Mr. Robert Bailey: Thank you, Ms. Gapp and Dr. Majumder, for coming in today and presenting. I was just

reading some of the stats here about the 27,000 long-term-care beds and 5,000 seniors' housing units. Are they spread pretty well all across the province or are there some parts of the province that are serviced better than others with those beds and those associations?

Ms. Cathy Gapp: That's a loaded question.

Mr. Robert Bailey: Oh.

Ms. Cathy Gapp: They are spread right across the province and, yes, there are varieties. There are variations. There are 300 elderly persons centres across the province as well.

Mr. Robert Bailey: Okay. I like the idea of what Mr. Fraser said. I know in my community of Petrolia, in my riding of Sarnia-Lambton, they're talking about a whole new concept called a "health care hub" involving seniors, long-term care and even palliative care, and building it in the general vicinity of the hospital. It would be their first major spend. I think some ideas from your association and coming out of this committee work today will probably serve them well when they're making those investments in that study group.

Thank you again for coming today. Is there anything you want to add in my time before we go on to the third party? Is there anything that you want to get on the record that you didn't feel you had the chance to say?

Ms. Cathy Gapp: No, we've had a chance to say everything. We are just very strongly supportive of not isolating seniors, healthy or frail, and making sure that everybody is part of an ongoing and building community.

Mr. Robert Bailey: Okay, thank you.

The Chair (Mr. Monte McNaughton): Thank you very much. We'll move to Madame Gélinas.

M^{me} France Gélinas: It's always a pleasure to meet with representatives of OANHSS. I'm a big fan. Thank you for what you do.

I don't agree with what the government is doing in this bill that would allow a for-profit company to be in charge of the elderly persons centres. I fully support the recommendations you have put forward, and I guarantee you that I will fight till the end so that our elderly persons centres, in their new renditions, will continue to be not-for-profit or charitable. It is a tough fight.

In the rest of the portfolio that you carry, have you seen other signs leading us to believe that more and more of elderly care goes to the for-profit rather than the not-for-profit?

Ms. Cathy Gapp: I wouldn't say we see more signs. Right now, the legislation prevents any transfer, for example, of long-term care licenses from not-for-profit to for-profit, so that cannot happen.

We don't think that this was an intentional way to open the door to the for-profits. Our concern is long-term interpretation. By it not being stated, that does open a door. We're constantly vigilant, and if we can protect it here, then I believe we can protect other avenues in the future.

M^{me} France Gélinas: I fully agree with you. I have no problem with First Nations—I have many of them in my riding—operating an elderly persons centre. Their views

of their elders are something that we can all learn from. They do this in a not-for-profit way already.

The other one is that for a for-profit entity to provide in-kind contributions—that has always been there, has it not?

Ms. Cathy Gapp: Yes, and we agree. It's always been there and there wasn't any reason to change the wording to allow that to continue to happen.

M^{me} France Gélinas: So there is no valid reason, as far as you can see, to do away with the mandatory not-for-profit or charitable?

Ms. Cathy Gapp: We don't see a valid reason, no.

M^{me} France Gélinas: I don't see it either. If they ever share a reason with you, would you please share it with me? Because this irks me to no end. Why are we changing the elderly persons centres under a bill that is called "patient safety"? Do you see any patient safety issues with our elderly persons centres? Is there any patient in an elderly persons centre?

Ms. Cathy Gapp: No, not that we're aware of.

M^{me} France Gélinas: Can you understand why the changes have been put into that bill?

Ms. Cathy Gapp: I would leave that to the House leaders and the legislative process. I wouldn't want to comment.

M^{me} France Gélinas: Okay. It's because they want to put privatization into our elderly persons centres without having a chance to debate it. This is why it is there. I'm against it, and I hate when they do that.

Thank you.

Ms. Cathy Gapp: Thank you.

The Chair (Mr. Monte McNaughton): And on that note, thank you for presenting today.

Ms. Cathy Gapp: Thank you.

COLLEGE OF AUDIOLOGISTS AND SPEECH-LANGUAGE PATHOLOGISTS OF ONTARIO

The Chair (Mr. Monte McNaughton): We'll now call upon the College of Audiologists and Speech-Language Pathologists of Ontario. Good afternoon and thank you for joining us today. You'll have six minutes for your presentation, followed by questions beginning with the official opposition. If you'd state your name for Hansard and begin, please.

Mr. Brian O'Riordan: Thank you. I am Brian O'Riordan, registrar of the College of Audiologists and Speech-Language Pathologists of Ontario, or as we're known by our acronym, CASLPO. I am joined today by Carol Bock, the deputy registrar, and Preeya Singh, who is the director of professional conduct.

Thank you to all members of the committee today for the opportunity to appear in order for us to submit our views on this very important piece of legislation before you, the Protecting Patients Act, 2017. We will be confining our remarks to schedule 4 of Bill 87, concerning the proposed amendments to the Regulated Health Professions Act.

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CASLPO licenses approximately 4,000 registrants currently, with 3,300 being speech-language pathologists and 700 being audiologists. Some 97% of speech-language pathologists are women, as are 80% of the audiologists registered with us. That's just to give you a bit of an overview of the college. As well, I wanted to let you know that a master's degree, combined with a six-month mentorship component, is required for entry to practice and to be licensed in the province. The professions became self-regulated in Ontario under the Regulated Health Professions Act in 1993.

We are here today to voice our overall support for schedule 4 of Bill 87 and to provide you with hopefully some interesting perspectives as the regulator of these two professions.

First of all, we absolutely support the zero tolerance for sexual abuse of patients that has been voiced by all three political parties in the Legislature. We also strongly support the submission made to you earlier today by the Federation of Health Regulatory Colleges of Ontario. Bill 87 will, we believe, enhance public protection and support strongly the zero-tolerance concept.

Like many colleges, we have in place a robust sexual abuse prevention program to regulate the members of the college. We also have a strong position statement on professional relationships and boundaries. This year, in fact, members of the college were required to review in detail the position statement as part of the annual quality assurance process which all members must go through each year. Prevention measures, I want to underline, are a key component of a college's responsibility and role as a regulator.

Fortunately, we have had, like our colleagues at respiratory therapy, very little front-line experience in receiving and processing sexual abuse complaints concerning the registrants of the college, but all of that, of course, can change, as we know.

However, it is vitally important that the public knows where and how to make a complaint about a regulated health professional. That is why all colleges, including ourselves, are devoting more and more effort and resources to public awareness strategies and transparency initiatives. In fact, this is one of our college's three major current strategic plan goals, as approved by our governing council.

Our college has revised its website to make information more accessible to the public. We have produced three public awareness videos, and we have brochures available in both official languages and in a half dozen other languages as well. Our material has been distributed throughout the province in community settings, hospitals, clinics, schools, waiting rooms etc. We have made this effort because we think it is vital that the public knows about the self-regulation, knows about the college and knows about the importance of being able to contact the college in the event that they need to make a complaint.

The patients cared for by speech-language pathologists and audiologists are among the most vulnerable members

of society in Ontario, and I do want to underline that for members of the committee. They are infants born with hearing loss. They are children, teens and adults with autism, developmental and language delays, and speech and hearing impairments. They are people who have suffered a stroke, head injuries and degenerative neurological diseases such as Alzheimer's and ALS.

These fundamental barriers to communication can make these individuals the most vulnerable to abuse and the least able to report that abuse. So that is why, at our college, we have developed strategies to promote better access to information for these individuals. You have to ask yourself, how does a person living with these kinds of communication or literacy barriers make a complaint? The college has developed resources that use simplified language, combined with pictures, to help people understand the role of audiologists and speech-language pathologists and how to make a complaint to the college if they need to do so. These documents have been reviewed by individuals experiencing communication barriers themselves, so as to ensure that the content is easy to understand and can be used efficiently and effectively by those populations.

The Chair (Mr. Monte McNaughton): Thank you very much. That's the time for your presentation.

We're going to begin questions with the official opposition. Mr. Yakabuski.

Mr. John Yakabuski: Thank you very much for joining us today, Mr. O'Riordan, and Ms. Bock and Ms. Singh. I had a chance to look through the submission as you were getting ready as well. Earlier, we had the—

M^{me} France Gélinas: Federation.

Mr. John Yakabuski:—Federation of Health Regulatory Colleges of Ontario. You're citing them in your submission as well, but I didn't see anything absolutely specific in your submission. In my discussion with the deputant from the federation, we talked about the lack of clarity when it comes to the definition of a patient. Is that something that you're concerned about as a group yourselves?

Mr. Brian O'Riordan: Yes, thank you very much for the question. As I said in the presentation, we do fully support the submission made by the federation. The federation's submission was put together through a consultative process with all of the colleges.

The content thereof: I didn't want to repeat it. But as I said, we fully support that content. We do think that there are some improvements—major improvements, in some cases—that need to be made with respect to the bill. In particular, the appendix to the submission made by the federation, in which they are suggesting some very important wording changes: We fully support that.

I don't want to give you the impression that we don't have concerns about the bill. Like all colleges, we do, but we feel that the federation has made the most comprehensive presentation on that. I wanted to bring to your attention other matters with respect to the role of colleges and the responsibilities that we feel we have for preventing sexual abuse and handling sexual abuse cases.

Mr. John Yakabuski: All of the written submissions do get reviewed. But for the purpose of being on the Hansard record, sometimes I think it's important to give you the opportunity to make that statement as well. That's the opportunity that is offered at committee—because we'll get many more written submissions from people who were unable to be here today for the purpose of appearing in person before the committee. We do review those, but in order to be put on the verbal record, we want to give people the opportunity to avail themselves of that.

We didn't have the chance with the federation, either, to verbalize all of their concerns, because their submission was of such a length that we were unable to do that.

Is there a specific amendment, whether it's in their submission or not—because I haven't had a chance to review it completely—that you would like to see in Bill 87?

Ms. Carol Bock: Just to speak to the issue of definition of “patient”—

The Chair (Mr. Monte McNaughton): I'm sorry to have to cut you off, but the three minutes are up.

Mr. John Yakabuski: Sorry, I talked too much.

The Chair (Mr. Monte McNaughton): We'll move to Madame Gélinas, please.

M^{me} France Gélinas: Go ahead and answer his question.

Mr. John Yakabuski: Thank you.

Ms. Carol Bock: We support the notion that definition has to be looked at, because even within our two professions, I think we may define that differently. For instance, an audiologist may see somebody very quickly and not have a very long, established relationship versus a speech pathologist who's working with a stutterer for five years. Even within the professions, I think there needs to be room for flexibility around that definition. I think, in each of those areas that FHRCO has highlighted, we could give you specifics related to our professions.

Mr. John Yakabuski: Thank you very much, and thank you, Ms. Gélinas.

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M^{me} France Gélinas: Continuing on, the bill will give the minister new power that compels the colleges to provide information, including personal health information about a member in certain circumstances. Has this ever happened to you before? Has the ministry ever asked for personal health information about one of your 4,000 members?

Mr. Brian O'Riordan: Not to my knowledge, specifically for any one particular member. I think it's important to understand, as well, that while many of the aspects that are in the bill were expected by us, there were some other things that were not as expected, and I think this one falls into that category.

M^{me} France Gélinas: Okay, very good. You are aware that the ministry has ways that—if a college was to go rogue, do you feel that the ministry would have a way to continue to protect the public?

Mr. Brian O'Riordan: In the absence of a regulatory college, I'm not sure at the moment that the ministry would have the resources or, indeed, the detailed background, skills and experience to immediately step into the role of a regulated college. We could have long conversations, of course, about the regulatory environment and the model that we have in Ontario.

But we feel that the model—I guess we're kind of attached to it. It's been around for a while. It does need, every now and then, to be refreshed, and this is an instance, I guess, with this bill, where some refreshment is needed. But I think that if you're asking me, “Could the ministry, tomorrow, step directly into the role of the college?” I would have to think “No.”

M^{me} France Gélinas: Thank you. And have you ever had sharing from the police coming to you regarding one of your members? So there was not a complaint made to your college, but one of your members ends up in front of the court and is found guilty of an offence. Would you know?

Ms. Preeya Singh: Yes. We have had that happen in the past.

The Chair (Mr. Monte McNaughton): That's all the time we have for questions from the third party.

We'll move to the government and Mr. Fraser.

Mr. John Fraser: You can finish your answer.

Ms. Preeya Singh: Yes, we have had that happen in the past, and the college conducted an appropriate investigation for that member.

Mr. John Fraser: Okay. Thank you very much for being here today. I want to especially thank you for the work that you've done around the vulnerable population that you serve. You expressed it very clearly. I'm not sure all members would know who your patients are.

We're talking here about trying to get the right balance, and these are really serious, very, very serious matters. From the point of view of transparency and some of the changes that we're looking at in the RHPA, how do you see that impacting your patients? Given the fact that I think you've gone to what sounds like some great effort to make sure that the complaints system was accessible and understood, do you have any comments on that?

Mr. Brian O'Riordan: Yes. I think that the important thing we were trying to underline is that the college doesn't have a role just in the processing of complaints about sexual abuse. That's important, but we have an equally important role in the prevention side and in the communication side. If people don't have the ability or the knowledge to make a complaint in the first place, then we aren't doing our role, we're not supporting our role.

That is why we wanted to highlight some of these things for you. Bill 87 will impact all of the colleges differently, and it will impact all of the various communities of patients that are served by the regulated professionals in the province. That's what we wanted to underline.

Mr. John Fraser: Thank you.

The Chair (Mr. Monte McNaughton): Great. No further questions? Thank you very much for your presentation today.

Mr. Brian O'Riordan: Thank you very much.

ONTARIO TRIAL LAWYERS ASSOCIATION

The Chair (Mr. Monte McNaughton): We'll now call upon the Ontario Trial Lawyers Association. Good afternoon. If you'd just state your name for Hansard, you have six minutes for your presentation.

Mr. Paul Harte: My name is Paul Harte. I'm a past president of the Ontario Trial Lawyers Association, and I'm here today on behalf of that organization to provide its comments on Bill 87.

Just by way of background, the Ontario Trial Lawyers Association, or OTLA, is an organization which has 1,600 members who represent victims of personal injury in Ontario. Our mission includes promoting access to justice, preserving and improving the civil justice system, and advocating for the rights of those who have suffered injury, but equally importantly, our organization's mission includes advocating and promoting safety. That's why I'm here today: to talk about safety in the context of the health profession.

I'm a medical malpractice lawyer. For more than 20 years, I have represented victims of medical mistakes, both in courts and within our health regulatory system. I have represented hundreds of individuals and their families who have been harmed in the health system. Sometimes the harm is a result of an unavoidable error, a momentary lapse in judgment. Sometimes it's a system error like a drug overdose. Rarely—although it does happen—the harm is caused by a health care professional who is either incompetent or unethical.

I would like to say for the record that based on my experience, the overwhelming majority of individuals who provide care to the people of Ontario are excellent. They form the foundation of a health care system of which we are all justifiably proud: the doctors and the nurses, the technicians and the therapists who quietly go about their business every day in the hospital.

Having said that, I'm not here to talk about them. I'm here to talk about the handful of professionals who are the source of preventable harm, and what you as legislators can do to prevent that harm. Indeed, that is the essence of what this act purports to do.

To give context to the problem, I thought it would be useful to talk about three specific examples of regulatory failure that I have personally been involved in in my career. While they are admittedly anecdotal examples, I believe that they serve to illustrate the problem that this Legislature is currently grappling with.

The first case happened in the 1990s. It involved a neurologist who had a technician who performed thousands of EEGs. The technician was using needle electrodes—putting needles underneath the skin—instead of using paste electrodes. The college was aware that this doctor was using needle electrodes, having done a survey

of all neurologists in Ontario, yet no attempt was made to stop this dangerous practice.

The college received a complaint from a foreign-trained doctor who was working in his clinic as a technician. That foreign-trained doctor wrote to the college to tell them about the risk of transmission of infectious disease. The college did not stop the doctor using needle electrodes. What the college did was go to the clinic and talk to the technician and tell him to stop using the term "doctor," because the technician had a PhD, and he was using the term "doctor." The college was very quick to enforce the monopoly that doctors enjoy, but neglected to prioritize the safety of patients.

In the end, 18,000 people received letters in the mail saying, "You may have been infected with hepatitis B, hepatitis C or HIV." A million dollars of taxpayers' money was spent testing and treating individuals. Some 1,200 people were infected. Two people died. That's the cost of regulatory failure.

The second case involves a surgeon in a small community in east Toronto. I assisted one of his former patients. It was a registered nurse. I was appalled with the care, and worked with her to make a complaint to the college. The college found that that doctor had made 11 different errors on six different occasions and referred him to quality assurance, not discipline. Quality assurance is a secretive process.

His rehabilitation, in any event, was mismanaged. He was never followed up on. He went on to continue practising in the community. I represented over 230 women. It was one of the largest compensations paid out—compensation which could have been used to provide that hospital with a new MRI or other care. He went on to continue his practice until finally, years later, the college revoked his licence.

The third example, much more recently, involves a surgeon by the name of Richard Austin. Richard Austin harmed more than 100 women as a surgeon. Complaints were made to the college. What did the college decide to do? The college accepted his resignation rather than pursue a discipline hearing—no consequences.

The patients were understandably outraged. They appealed to the Health Professions Appeal and Review Board, and that board responsibly ordered the College of Physicians and Surgeons to send him to discipline—enormously important because of the issue of general deterrence.

This brings me to the issue of sexual assault and sexual abuse. The changes addressed in section—

The Chair (Mr. Monte McNaughton): Thank you for your presentation. The six minutes are up.

We'll move now to Madame Gélinas.

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M^{me} France Gélinas: Please continue.

Mr. Paul Harte: The issue of sexual abuse is extraordinarily important. While colleges have a stated policy of zero tolerance, it must be followed up with stern discipline action, not only for the specific deterrence—

we have to get that doctor or nurse or health care practitioner out of the system—but for general deterrence.

It is evidently not enough. The doctors, in particular, have not learned the lesson. They must remove their licence to ensure that it doesn't happen again in the future.

M^{me} France Gélinas: Do you feel we have the right balance now with Bill 87? Have we got the right balance so that the three examples you've just given us will not happen?

Mr. Paul Harte: Here's the reality: This should be a wake-up call to the colleges. This is essentially moving from a self-regulatory model to a hybrid model. If the hybrid model does not work, the government will have to step in and take over control.

Self-regulation is a very tricky business. There is an inherent conflict of interest. I say it about lawyers as well. How do we regulate ourselves when it is affecting ourselves? Imagine a banker regulating himself.

I understand that we've got a historical context. Fair enough—try and fix the system. But this has to be the last chance, and if it does not work, the government has to take over the role.

M^{me} France Gélinas: Some of the recommendations made by the committee that advised were that the colleges should not be the ones investigating those types of complaints—that those types of complaints should be investigated elsewhere. Is this where you're pointing us to?

Mr. Paul Harte: If the government took over regulation, it would be a unified model for regulating all health care professionals: economies of scale; one institution that could, for example, investigate multiple health care professionals' care in the context of an individual patient. It would be much more efficient than the current system we have.

M^{me} France Gélinas: Does this exist anywhere?

Mr. Paul Harte: Yes. There are models around the world. In fact, increasingly, I believe that Western civilization is moving away from self-regulation. Essentially, the only reason for it is that doctors, for example, have special knowledge. Well, we have judges in this province who deal every day with difficult medical issues, and they do that with the assistance of medical experts.

The tool is not to know the medicine; the tool is to be a regulator and have the knowledge of what that is. That is the most important, and I see that as a growing trend.

M^{me} France Gélinas: That cannot be fixed through Bill 87, because Bill 87 continues with the self-regulated model.

Mr. Paul Harte: As I see it, Bill 87 is a shot across the bow, that the Minister of Health is going to be more actively involved unless the colleges start regulating the health profession. We have to stop reading about the colleges on the front page of the Toronto Star.

M^{me} France Gélinas: Thank you.

The Chair (Mr. Monte McNaughton): Thank you very much. We'll move to the government now, and Ms. Kiwala.

Ms. Sophie Kiwala: Thank you very much, Mr. Harte, for being here today, and thank you for your professional work that you're doing. You've got some great experience in the field—20-plus years—and that's impressive.

I think you started with a statement that is very important to reiterate, that this is about advocating and promoting safety. That is why we're here; that is why we're bringing forward that legislation.

You also very adequately describe the fact that this legislation is not being created for our average or above-average medical practitioners. It is the unscrupulous and unethical actors that this is aimed for. If we have to create legislation for the minority of cases, then that's what we need to do, and that is what the case is here.

A very important part of this legislation is the addition of funding for patient therapy and counselling from the moment a complaint is made. I'm wondering if you can speak to how important it is to support patients as soon as they initiate a complaint.

Mr. Paul Harte: Certainly. First of all, let me start by saying that the government really ought to be congratulated. This has been a process that has been going on for 20 years, and there hasn't been the political will to put this on the burner. To whatever extent that there may be imperfections, it is much, much better to have than not to have.

The funding with respect to therapy is enormously important. I'll tell you it this way: The government, because we have a publicly funded health care system, including a publicly funded compensation system, is going to pay the bill sooner or later. When you have therapy early, and help and support these individuals, you're going to have significantly less harm, and it's financially responsible as well.

Ms. Sophie Kiwala: Okay. Thank you. We are committed, as you know, to strengthening sexual abuse provisions and improving the complaints, investigation and discipline process for sexual abuse cases. How do you see these proposed amendments improving both patient care and the integrity of the medical profession?

Mr. Paul Harte: I see that the legislative changes are a good step forward. They eliminate some technical issues, for example, with respect to the definition of what sexual abuse is.

Having said that, I would like to emphasize that it has to be met with a commitment to implement the legislative powers that are being given to the colleges. Practising a health profession in this province is a privilege, not a right. If you go over that line of sexual abuse, there really is no societal value to having those continue to practise.

Ms. Sophie Kiwala: Thank you very much. I have no further comments.

The Chair (Mr. Monte McNaughton): Right on time. We'll move to Mr. Yakabuski and the official opposition.

Mr. John Yakabuski: Thank you very much, Mr. Harte, for joining us today.

I'm not going to try to put words in your mouth, but if I'm reading between the lines, if you had your way, all

self-regulatory bodies would be dissolved and we would have regulation at the government level, and that would include the Law Society of Upper Canada?

Mr. Paul Harte: I think that's absolutely true. I've publicly been on the record speaking personally on behalf of that. But I also recognize that my personal desires don't always end up as the result of a democratic process. So there may well—

Mr. John Yakabuski: You did get elected president of the trial lawyers.

Mr. Paul Harte: I'm sure that's because there was nobody else who was prepared to take the position.

Mr. John Yakabuski: You're too modest.

We've heard from the government that this would be an onerous process, but for the Attorney General to get all the information back to the college of someone who was under investigation or charged or bail hearings—any of those issues—it would be difficult for the government to get that information back, the reverse of what most people would think. They would think that the college would be aware of this, but if they're not—you're a trial lawyer. You understand the legal system a whole lot better than I do. Is that something that should be so difficult, or is there a way that this could be made to work in a very orderly fashion so that as a matter of course, if someone is before the legal system, that information in a timely fashion is transferred back to the respective college?

Mr. Paul Harte: It would be relatively straightforward to fashion a solution with greater information-sharing. In fact, that has to be encouraged.

At the same time, we need to ensure that that information is protected and provided to only those individuals who need to have that information. We do that all over the place. We do that in the fight against terrorism. There's no reason why our regulators should have their hands tied behind their back. There is always a happy medium where you can have some safeguards to ensure privacy, but ensure that the public is at all times protected.

Mr. John Yakabuski: Thank you very much. We appreciate you visiting today.

Mr. Paul Harte: Thank you for the opportunity.

The Chair (Mr. Monte McNaughton): Great. Thank you for your presentation today.

VACCINE CHOICE CANADA

The Chair (Mr. Monte McNaughton): We now have on the line a representative from Vaccine Choice Canada. Ms. Fraser, are you on the line?

Ms. Heather Fraser: Yes, hello.

The Chair (Mr. Monte McNaughton): Welcome. You'll have six minutes for your presentation followed by questions, three minutes from each caucus, beginning with the government. If you'd state your name for Hansard. You can begin your presentation.

Ms. Heather Fraser: My name is Heather Fraser. I'm speaking on behalf of Vaccine Choice Canada and

myself about the proposed amendment to the Immunization of School Pupils Act.

Most MPPs do not seem to understand why parents are questioning the safety of vaccinations. I did not understand the associated risk either until I took my infant son for his first shot. He received the penta vaccine at two, four and six months of age. After each injection, he screamed in pain for hours. The pain persisted through his first year of life, during which he also developed eczema, asthma and environmental and food allergies. At age one, he reacted violently to peanuts.

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Because of our experience, I took the time to understand vaccine injury and vaccine-induced allergy and anaphylaxis. I have written a book, *The Peanut Allergy Epidemic*, in which I explain that vaccination is the precipitating cause of this pediatric epidemic. The book's foreword is written by another peanut allergy parent, Robert F. Kennedy Jr.

Toronto allergist Peter Vadas, at St. Michael's Hospital, commented in 2001 on early childhood vaccinations and antibiotics. One of the spinoffs he stated is that a certain proportion of the population is going to be prone to developing allergies as a consequence of that. Yes, there is ample medical literature that explains how vaccine ingredients such as aluminum augment sensitization to non-target substances. In other words, vaccination can and does create allergies not only to what is in the vaccine, but also to bystander proteins—to anything in and around the body at the time of the procedure. Once the child's immune system has tipped into allergy, there is increased risk of developing more allergies.

My son and thousands of other Canadian children received penta vaccine between 1994 and 1997. I suspected we were not the only ones injured by it, so I requested and received from the Public Health Agency of Canada all of the Adverse Events Following Immunization reports, or AEFI reports, for this vaccine. There were over 11,000 reports that described what the children experienced. These included head-banging; ear infections; furious blinking; anorexia; asthma attacks; lethargy; shaking; rapid eye movements; vomiting; somnolence; ice-cold hands and feet while with fever; hypokinesia, which is an inability to move; inconsolable screaming; and abnormal gait following vaccination, where the child hobbled with a deformity of the leg. Yet another child experienced myoclonic seizures. With a recommendation to defer immunization, one child was doped up. Another was red and swollen from head to toe. There were rashes, involuntary contractions, a crisis of rotating eyeballs, tremors, limpness, and numerous seizures. There were hospitalizations, and 15 deaths reported. It was determined that one child died from cerebral infarction following immunization, and another suffered brain and spinal cord inflammation.

Anyone reading these reports would wonder about the long-term health of the surviving 11,000 children, but because there was no case-by-case follow-up, government does not know. As well, we can be sure that there were far more than 11,000 adverse events.

The under-reporting of adverse events is an enormous problem for our passive vaccine surveillance system. According to the Public Health Agency of Canada, there were over 115,000 adverse events between 1987 and 2011, and 85% of them were children. But this represents just 10% of all events. In other words, as many as 980,000 adverse events may have occurred in children in those years—that no doubt include life-threatening allergy—about which we have no data.

To be blunt, we have limited data on injuries in the AEFI reports, do not know the full scope or nature of adverse events that are massively under-reported—and take no action to acknowledge or support those injured.

In this vacuous state, government has seen fit to increase the number and complexity of the vaccines anyway. Between 1988 and 1994, the pediatric schedule increased significantly. In the same period, neurological injuries and allergies in children also increased.

The sudden start of this epidemic is confirmed by ER records, cohort studies and eyewitness accounts of teachers confronted by a surge of allergic children in the early 1990s. Today, 8% of children under three have life-threatening food allergies.

The schedule has continued to expand and has never been tested for safety as a whole. In 1983, up to age four, children received 22 doses of seven vaccines. This has doubled: Today, children receive prenatal vaccines via the mother, are injected at birth and receive a total of 49 doses of 14 vaccines.

It is the law in Ontario that vaccine recipients must be informed of the risk, give their consent voluntarily—which is also a charter right—and be reminded to watch for adverse events. Government is prepared, however, to erode informed consent through mandatory education sessions, and to continue to remain passive on adverse events. Actual follow-up on each AEFI report would yield crucial data from which we could identify trends and make a safer schedule, but there is no incentive to do this. It is cost-effective for government not to collect meaningful data and to download the costs of injury to children and their families.

The Ontario government's response to parents of vaccine-injured children, like myself and other worried parents today, is not to seek better consumer protections and not to investigate but, rather, to bully mothers into accepting one-size-fits-all injections they don't want and for which the government accepts no responsibility in the event of an adverse outcome.

MPPs have stated in the House that mothers are uninformed. On the contrary, the MPPs, except one, who spoke in the House on vaccination are unaware of what is taking place in their own province. The amendment to the ISPA proposed in Bill 87 would deepen the crisis of chronic health problems in our children by attempting to indoctrinate mothers into believing vaccines are safe, when they are not. By law and in fact, vaccination is a medical procedure for which there are documented risks and obvious injuries more extensive than the government seems prepared to investigate.

The Chair (Mr. Monte McNaughton): Ms. Fraser? It's the Chair, MPP McNaughton. The six minutes is up and we're going to move to the government now for questions. We'll move to Mr. Fraser.

Mr. John Fraser: Ms. Fraser, if you've got a little bit to finish, please go ahead.

Ms. Heather Fraser: I had one sentence left, simply that we ask that this amendment be withdrawn.

Mr. John Fraser: Okay. Thank you, Ms. Fraser, for your deputation. The Immunization of School Pupils Act has passed. Exemption from immunization requirements are going to continue to be allowed for medical reasons, religious reasons or reasons of conscience.

Do you or your members have an objection to, as is described in the bill, as a family, any information session?

Ms. Heather Fraser: Yes.

Mr. John Fraser: What would that objection be based on?

Ms. Heather Fraser: The objection would be based on the erosion, in part, to informed consent, which is in the Ontario Health Care Consent Act. These education sessions, in whatever form they may take, challenge their rights to fully understand the risks that the parents are confronting. These education sessions are not for everyone. They are not about being balanced in the information that is being provided because there are only four parents who are requesting exemptions for their children.

Our concern is that whatever information is going to be provided to these parents, that it would not be balanced at all.

Mr. John Fraser: Thank you very much.

The Chair (Mr. Monte McNaughton): Great. I will now move to the official opposition and Mr. Yakubuski.

Mr. John Yakubuski: Thank you very much, Ms. Fraser, for joining us via teleconference today.

So what are you saying, that there should be an equal amount of education on what are considered by some to be the dangers of vaccination?

Ms. Heather Fraser: That would be ideal, yes, if the government would provide transparency with regard to the risks associated that are evident in every vaccine package insert, for example. But also, there is not adequate tracking of the injuries that are occurring. There's no investigation into them at all. When these reports are made by doctors and submitted to the public health agencies, there is no follow-up on any of these children individually on a case-by-case.

We really do not understand the scope and the nature of vaccine injuries. Our concern is that while government seems to be prepared to push mothers harder and further to vaccinate their children—and at the same, the government is not accepting responsibility for the injuries, and they're not investigating the injuries that are presented to them.

Mr. John Yakubuski: Okay. If I can ask you—and if I'm asking you something inappropriate, just don't answer—you mentioned that your son had eczema as a

result of a vaccination, before he was a year old, based on what you stated, unless I heard you wrong.

Ms. Heather Fraser: Yes.

Mr. John Yakabuski: I don't know how old your son is today. If I'm allowed to ask that question, does he still suffer from eczema?

Ms. Heather Fraser: He is 22 now and he continues to be allergic to peanuts and nuts. We worked very hard to recover his health. He is better but he is still anaphylactic, which means he has life-threatening allergies today.

Mr. John Yakabuski: If I can ask, was there a medical opinion that the eczema was contracted as a result of the—I didn't hear you clearly as to the specific vaccination, but the eczema was contracted as a result of the vaccination?

Ms. Heather Fraser: At the time, there was much confusion and I had to go back to research on my own to understand. I would tell you that the medical literature reflects very clearly, and there's a lot of research in this, that vaccination does precipitate, does create, allergies in children, and eczema is a form of allergy. Allergy will manifest in many ways in children: eczema is one of them, and asthma, skin conditions and full anaphylaxis, which is a very violent reaction that can kill.

I did mention Dr. Vadas at St. Michael's Hospital—

The Chair (Mr. Monte McNaughton): Ms. Fraser, we have to move now to the third party and Madame Gélinas for questions.

M^{me} France Gélinas: Good afternoon. Thank you for the information that you shared with us.

I'm just looking at—would it make it better, I guess, if we added a part to the bill that would focus on collecting adverse effects and injuries following vaccines, which parents could fill in themselves, and make that process transparent, so that everybody could see it?

Ms. Heather Fraser: In the Health Protection and Promotion Act, there is also information where the person who is providing the vaccine, the doctor, is to instruct people to report. That does already exist. I don't think that there is a form for that other than what is held by the doctor himself, but I'm not sure that that is being followed up on. Are people being warned? There doesn't seem to be any surveillance on that.

There needs to be, I think, more of a proactive approach. You're quite right. I don't know where it would fit exactly. My concern with the current amendment, however, with these education sessions, is that they will not be balanced. As I said, they are not for everyone; they are just for people requesting exemptions, so it provides an opportunity for—I hesitate to say the word "abuse" of the situation, but that is a very real risk that may happen, where the parent is not provided with the full information that, by law, they should have. That's called informed consent.

M^{me} France Gélinas: Because we haven't seen the content of what kind of information will be given to those parents?

Ms. Heather Fraser: That's right. We don't know the tone. We don't know the manner. Is it an actual classroom? Is it going to be online? I would certainly be encouraging parents to record and document whatever is taking place, so that they know that their rights are being upheld.

M^{me} France Gélinas: Thank you.

The Chair (Mr. Monte McNaughton): Thank you, Ms. Fraser, for your presentation today.

I'd like to thank all the presenters today and thank the committee.

Our next meeting is Wednesday, April 26, 2017, at 12:30 p.m. Enjoy the Easter weekend and next week.

The committee adjourned at 1443.

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